

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12343					12352				
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural d. STREET ADDRESS RFD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MYRA Middle EMMA Last ALDRIDGE			4. DATE OF DEATH Month September Day 28 Year 19 67						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1891		9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) Hurlock, Maryland, RFD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Annie Garris				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Winifred Aldridge, Hurlock, Maryland Address 				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes mellitus 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetic gangrene								INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January 8, 1967 to September 28, 1967 , that (I) (we) last saw the deceased alive on September 28, 1967 , and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE Carlos F. Barroso M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO					22d. ADDRESS Hurlock Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery		23d. LOCATION (City, town or county) (State) Hurlock, Maryland RFD		
24. FUNERAL DIRECTOR J. J. Frampton and Son ADDRESS Federalsburg, Maryland					25a. REC'D BY REGISTRAR OCT 5 1967 25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

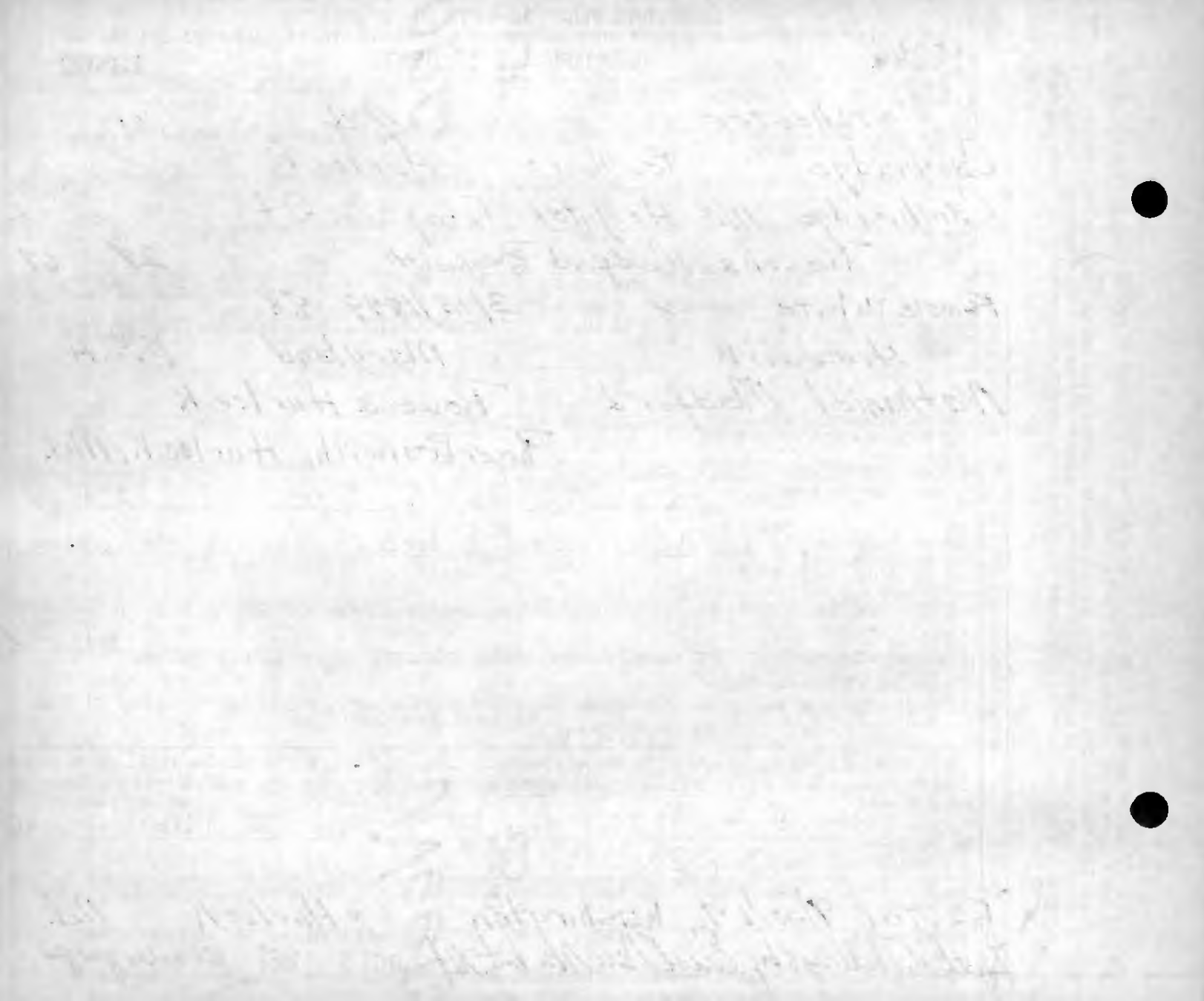
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12344

13802

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			
c. LENGTH OF STAY IN 1b <u>Few Hours</u>				d. STREET ADDRESS <u>Thompson St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rowena Medford Beckwith</u>		First Middle Last		4. DATE OF DEATH <u>9 29 1967</u>		Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/1919</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathaniel Medford</u>				14. MOTHER'S MAIDEN NAME <u>Rowena Hurlock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>Roger Beckwith, Hurlock, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1966</u> , to <u>September 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>September 27, 1967</u> , and that death occurred at <u>11:55</u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>Carlos F. Barroso</u>				22b. DATE SIGNED <u>September 27 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>	
				22d. ADDRESS <u>Hurlock Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		23d. LOCATION (City, town or county) (State) <u>Hurlock Md.</u>	
24. FUNERAL DIRECTOR <u>Kath. J. Milbray, East New Market, Md.</u>				25a. REC'D BY REGISTRAR <u>10 OCT 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

12345

12353

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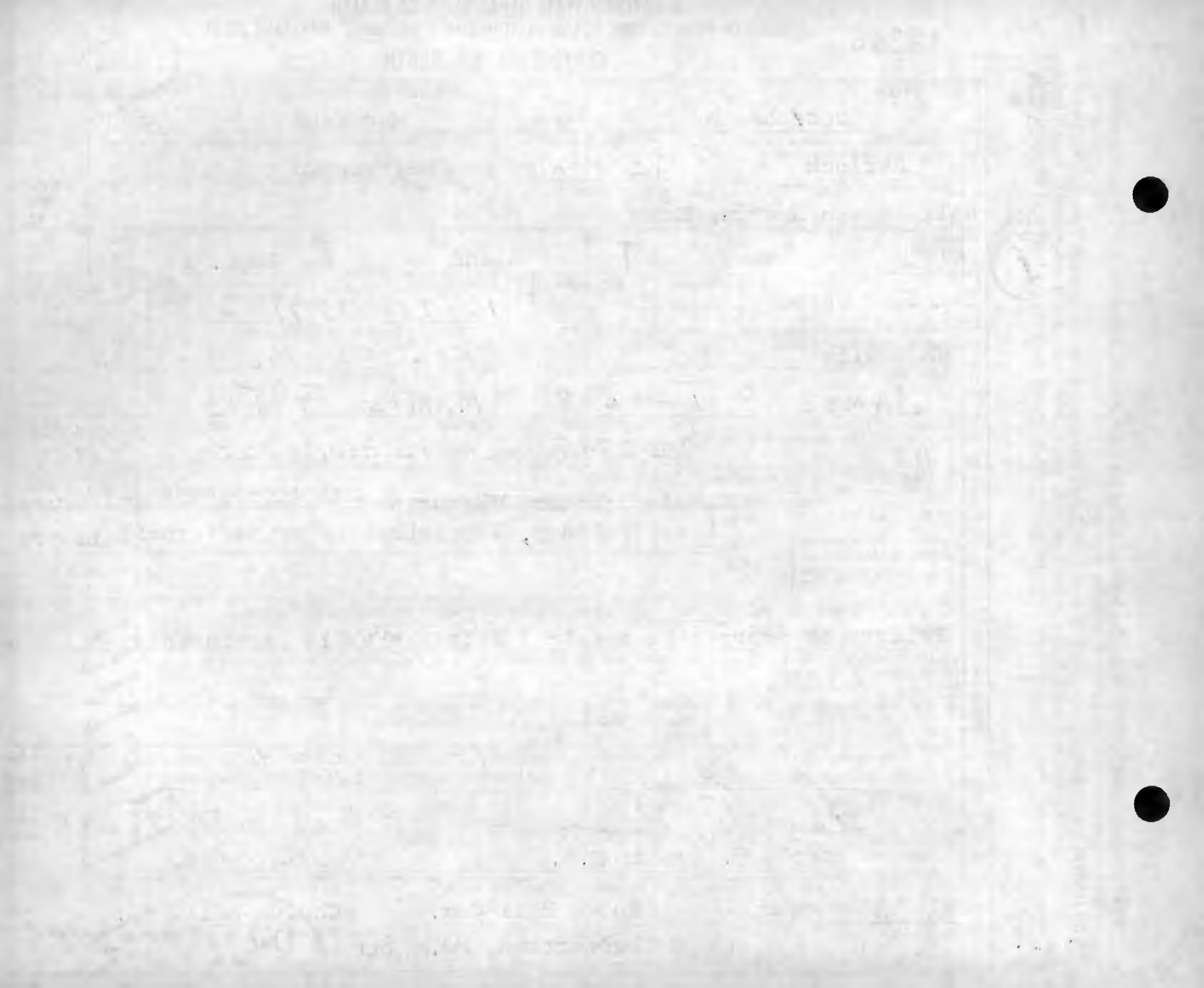
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 9 mths	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SALLY Middle WILLEY Last BELL		4. DATE OF DEATH Month Sept. Day 2, Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Willey		14. MOTHER'S MAIDEN NAME Sarah Ann Matthews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mr. E John H. Bell, Cambridge, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 30, 1967 to Sept 2, 1967 that (I) (we) last saw the deceased alive on Sept 2, 1967 , and that death occurred at 9 P M, from causes and on the date stated above.			
22a. SIGNATURE Lewis M. Burdette		22b. DATE SIGNED 5 Sept 67	
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette		22d. ADDRESS 4 Aurora St, Cambridge, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 5 1967	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

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VR A15 (4)
25M 1/67

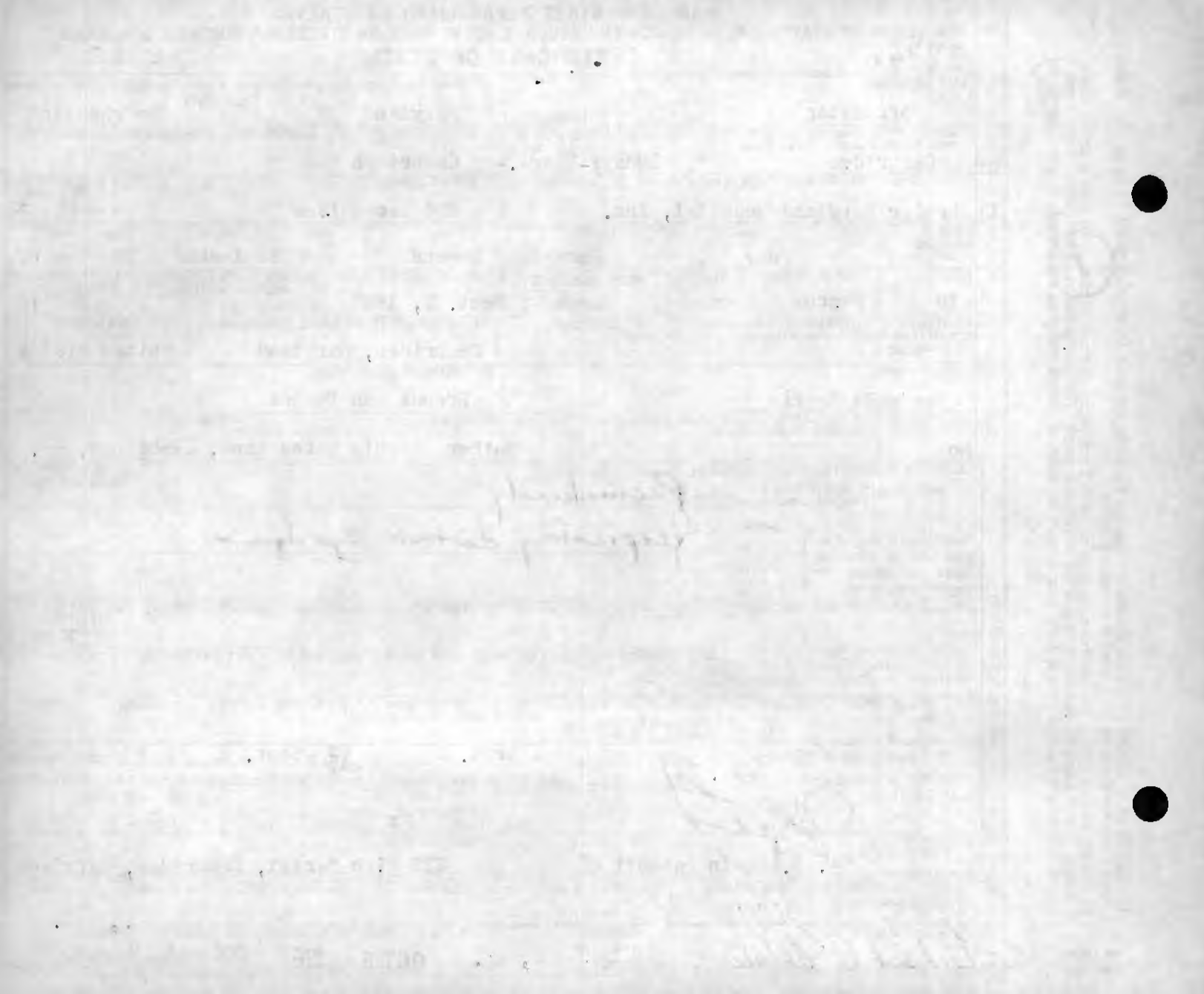
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 12346 CERTIFICATE OF DEATH 12354 </div>											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock				c. LENGTH OF STAY IN 1b 5 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belle Haven Nursing Home						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth T Bland						4. DATE OF DEATH Month Sept. Day 13 Year 1967					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/1895		9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) KENT CO Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JAMES S. TAYLOR						14. MOTHER'S MAIDEN NAME MARTHA FITZIS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 214-288592		17. INFORMANT NURSING HOME RECORDS				Address HURLOCK Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion due to Coronary DUE TO insufficiency, Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Primary or macrocytic anemia ? Left Breast Metastasis Old Carcinoma										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/4 , 19 67 , to 9-13 , 19 67 , that (I) (we) last saw the deceased alive on 9/11 , 19 67 , and that death occurred at 8:45 AM , from causes and on the date stated above.											
22a. SIGNATURE Harold B. Plummer						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/13/67			
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer M.D.						22d. ADDRESS Preston Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/67		23c. NAME OF CEMETERY OR CREMATORY Church Hill Cem.				23d. LOCATION (City or Town) (County) (State) Church Hill, Md.			
24. FUNERAL DIRECTOR J. Willis Wells				ADDRESS Chestertown, Md.		25a. RECD BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE [Signature]			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12347					12355				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 20 days - 23 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital, Inc.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 804 Maces Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Tony Middle Howard Last Bowens			4. DATE OF DEATH Month September Day 23 Year 19 67						
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1967	9. AGE (In years last birthday) — yrs.	IF UNDER 1 YEAR Months 20 Days 23 Hours 15	IF UNDER 24 HRS. Hours 23 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Benjamin Harris					14. MOTHER'S MAIDEN NAME Brenda Ann Bowens				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mother Address 814 Maces Lane, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 773.5 IMMEDIATE CAUSE (a) Prematurely Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Respiratory distress syndrome (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 12			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 2, 19 67 to Sept. 23, 19 67 , that (I) (we) last saw the deceased alive on Sept 22 19 67 , and that death occurred at 12 AM , from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED 10-2-67				
22c. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett					22d. ADDRESS 623 High Street, Cambridge, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 9/24/67		23c. NAME OF CEMETERY OR CREMATORY RHODESDALE		23d. LOCATION (City, town or county) (State) DORCHESTER CO. MD.		
24. FUNERAL DIRECTOR [Signature]					ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR OCT 5 1967		25b. REGISTRAR'S SIGNATURE [Signature]

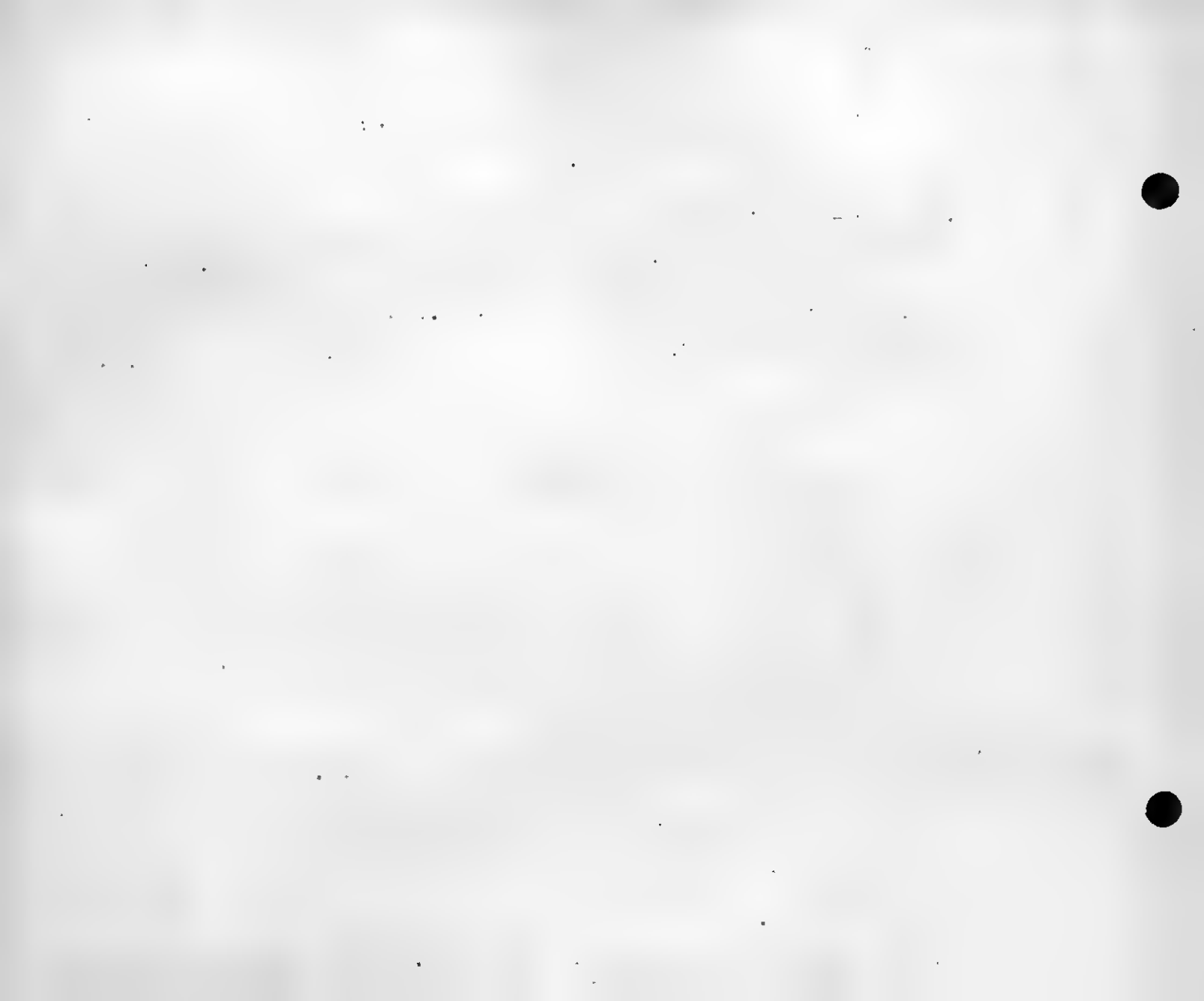


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432
10/19/67

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12348 CERTIFICATE OF DEATH 12356													
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>8 hours</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROYAL OAK</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Slater</u> Last <u>Calloway</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Sept. 18, 1884</u>			9. AGE (In years last birthday) <u>83</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot County</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Marion Leoard</u>						14. MOTHER'S MAIDEN NAME <u>Emma Kornauer</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Address</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolus</u> <u>+65X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bedrest, prolonged</u>												INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5 1967</u> , to <u>9-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-26</u> 19 <u>67</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Richard G. Bilodeau</u>						22b. DATE SIGNED <u>9-27-67</u>			22c. PHYSICIAN'S NAME (Type) <u>RICHARD G. BILODEAU</u>				
22d. ADDRESS <u>CITY OFFICE BLDG., CAMBRIDGE, MD</u>						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct. 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Easton, Maryland</u>				
24. FUNERAL DIRECTOR <u>R. Ellis Clark Funeral Home, Easton, Md.</u>						25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12349

12357

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c LENGTH OF STAY IN TB 1 hour	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spencer Jones Labor Camp		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ROBERT DAVIS		4 DATE OF DEATH Month September Day 26 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 26, 1967
9 AGE (In years last birthday) yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Hurlock, Md., R.F.D.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Joe Nelson Davis		14 MOTHER'S MAIDEN NAME Elberta Rollace	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT Joe N. Davis, Hurlock, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Post partum neglect 7/15.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M.D.		22. DATE SIGNED 10/2/67 Cambridge, Md.	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF Oct. 2, 1967	
23c NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery		23d LOCATION (City or Town) (County) (State) Near Rhodesdale, Maryland	
24. FUNERAL DIRECTOR <i>J. J. Frampton</i> J. J. Frampton and Son, Federalsburg, Maryland		25a REC'D BY REGISTRAR OCT 5 1967	
25b REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>			

CERTIFICATE OF DEATH

12350

12358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS UNIONVILLE ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last GRANVILLE JAMES DICKERSON		4. DATE OF DEATH Month Day Year SEPTEMBER 15 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-23-80
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. JS JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) POCOMOKE CITY MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CALEB DICKERSON		14. MOTHER'S MAIDEN NAME HARRIET SCHOOLFIELD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 213-14-6394	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME ARTERIOSCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 09-08-67		20f. (City or town) (County) (State) 09-15-67	
21. I certify that (I) (this hospital) attended the deceased from SEP. 15, 1967 , to SEP. 15, 1967 , that (I) (the) last saw the deceased alive on SEP. 15, 1967 , and that death occurred at 9:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Edward Lewis, Jr., MD		22b. DATE SIGNED 9-15-67	
22c. PHYSICIAN'S NAME (Type) EDWARD LEWIS, JR., MD		22d. ADDRESS ESSH CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/67	
23c. NAME OF CEMETERY OR CREMATORY Unionville, Cem.		23d. LOCATION (City or Town) (County) (State) Pocomoke City, Md.	
24. FUNERAL DIRECTOR James H. Long		25a. REC'D BY REGISTRAR SEP 20 1967	
25b. REGISTRAR'S SIGNATURE James H. Long		25c. REGISTRAR'S SIGNATURE James H. Long	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12351

12350

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (rural)</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>109 West View Apt House</u>	
3 NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Lyons</u> Last <u>Foster</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/87</u>
9 AGE (In years last birthday) <u>80</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edward Lyons</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO <u>301X</u> (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO <u>1 yr 9 mos</u> (c) <u>1 yr 9 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME; Post-CVA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>11-1-</u> 19 <u>65</u> to <u>9-17-</u> 19 <u>67</u> , that (1) (this) saw the deceased alive on <u>9-17-</u> 19 <u>65</u> , and that death occurred at <u>7:00</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>E. Lewis</u>		22b. DATE SIGNED <u>9-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR. MD</u>		22d. ADDRESS <u>E.S.S. N.Y. CAMBRIDGE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent's</u>	23d. LOCATION (City or Town) (County) (State) <u>St. Vincent's</u>
24. FUNERAL DIRECTOR <u>John Thibault</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



12352

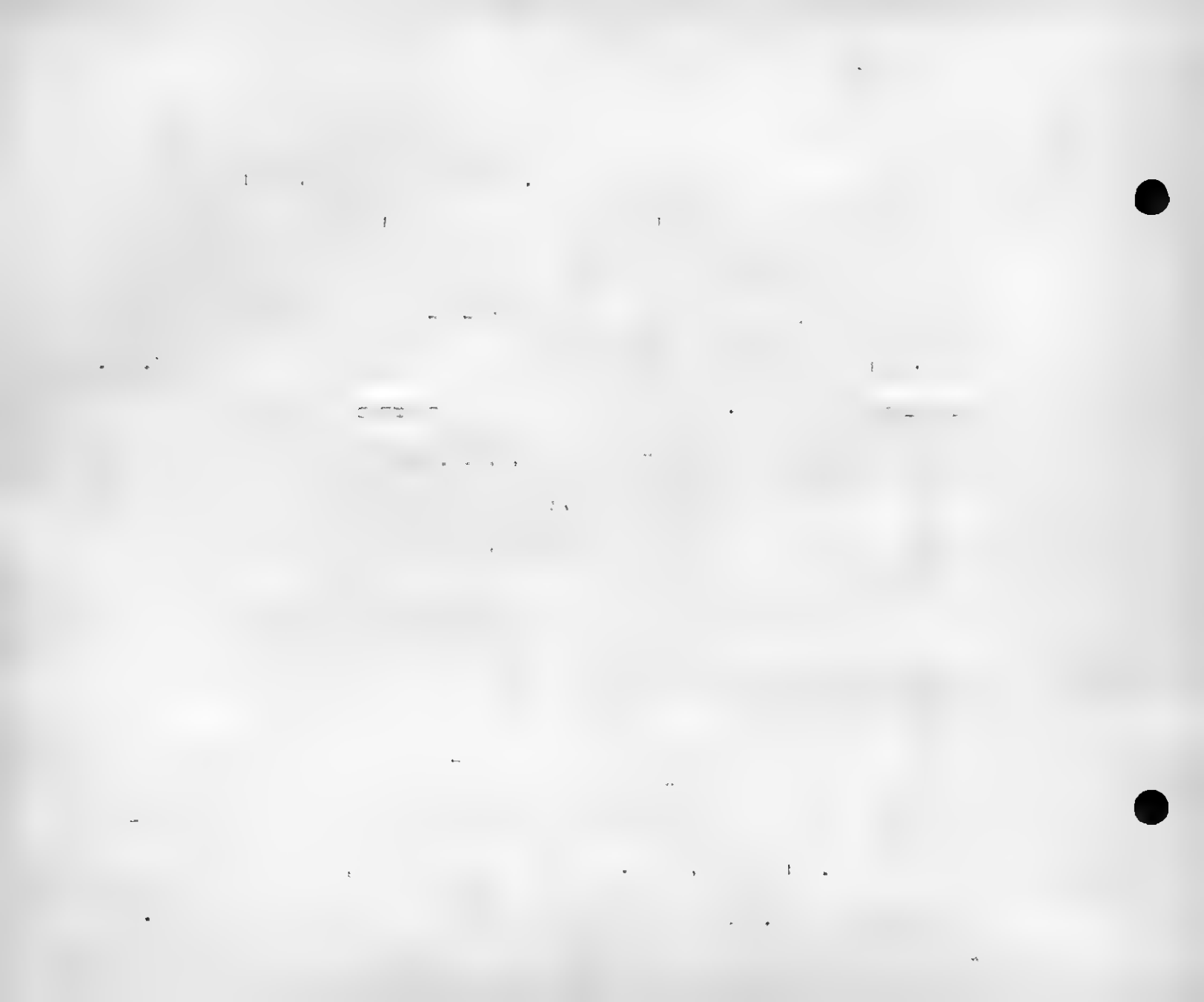
CERTIFICATE OF DEATH

12360

1 PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 2 YRS. 2 MO. 2 DAYS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS HALL HIGHWAY	
3. NAME OF DECEASED (Type or print) First Middle Last DAISY Rae GANDY		4. DATE OF DEATH Month Day Year 09 28 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-06-84
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME George T. Nelson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-38-8474	
17. INFORMANT E.S.S.H. RECORDS		Address CAMBRIDGE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 07-26 , 19 65 , to 09-28 , 1967, that (I) (we) last saw the deceased alive on 09-28-19 67 , and that death occurred at 9:30AM , from causes and on the date stated above			
22a. SIGNATURE <i>Richard G. Bilodeau</i>		22b. DATE SIGNED 09-28-67	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD G. BILODEAU		22d. ADDRESS E.S.S.H., CAMBRIDGE, MARYLAND 21613	
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF Oct. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	23d. LOCATION (City or Town) (County) (State) Crisfield, Md.
24. FUNERAL DIRECTOR Bradshaw & Sons		25a. REC'D BY REGISTRAR OCT 4 1967	
ADDRESS Crisfield, Md		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12353

12361

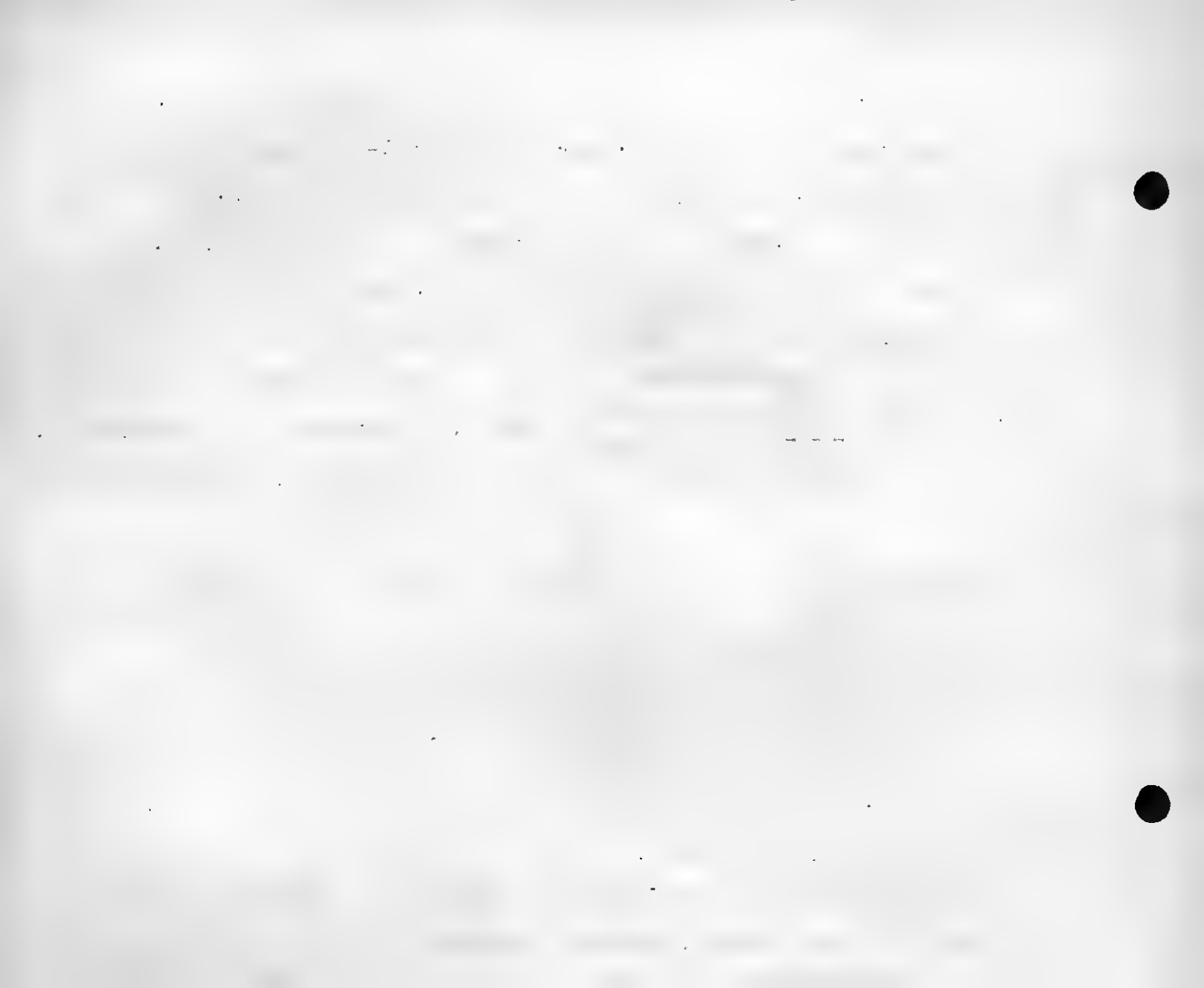
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 16 mths	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 317 Choptank Avenue		d. STREET ADDRESS 317 Choptank Avenue	
3. NAME OF DECEASED (Type or print) First ALBERT Middle J. Last GARVAN		4. DATE OF DEATH Month Sept. Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1907
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk		10b. KIND OF BUSINESS OR INDUSTRY Unk	
11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO Unk	
17. INFORMANT Mrs. Omie Cantrell, 317 Choptank Avenue, Cambridge, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1201	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type)		22. DATE SIGNED 9/30/67 Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City or town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REG. STRAR OCT 2 1967	
25b. REGISTRAR'S SIGNATURE John Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Cambridge d. STREET ADDRESS RFD No. 3, Todd Point e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) EMMA DORA GLENN		4. DATE OF DEATH Sept. 26, 19 67		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1883		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alexander Friech				14. MOTHER'S MAIDEN NAME Margaret Turnbull				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. unk				17. INFORMANT Address Mrs. G. P. Richards, RFD 3, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postero-lateral myocardial Infarction DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ?												INTERVAL BETWEEN ONSET AND DEATH 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9/19/67, 19 to 9/26/1967 , that (I) (we) last saw the deceased alive on 9/26/67 19, and that death occurred at 9:00 AM , from the causes and on the date stated above.																			
22a. SIGNATURE Lancee Maryann				22b. DATE SIGNED 9/26/67				22c. PHYSICIAN'S NAME (Type) Lancee Maryann				22d. ADDRESS 610 Race St Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept 28, 1967				23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION (City, town or county) (State) Baltimore, Maryland							
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR SEP 23 1967				25b. REGISTRAR'S SIGNATURE J. Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12355

12364

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN 1b <u>7 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		d. STREET ADDRESS <u>Ridgely</u>	
3. NAME OF DECEASED (Type or print) <u>William Harrison</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1887</u>
9. AGE (in years, last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cash Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Clinton Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Stafford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>25-20-0720-Records-Hospital</u>	
17. INFORMANT <u>Records-Hospital</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Lobar Pneumonia.</u> DUE TO (b) <u>Senile cachexia</u> DUE TO (c) <u>Carcinoma of Prostate gland</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>February 2, 1967</u> to <u>September 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>September 7, 1967</u> , and that death occurred at <u>4 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Carlos F. Barroso</u>		22b. DATE SIGNED <u>September 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>		22d. ADDRESS <u>Hurlock Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-9-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>	23d. LOCATION (City or Town) (County) (State) <u>Ridgely, Md.</u>
24. FUNERAL DIRECTOR <u>J. E. Boucous Greensboro, Md.</u>		25a. RECD BY REGISTRAR <u>SEP 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u></u>		25c. REGISTRAR'S ADDRESS <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

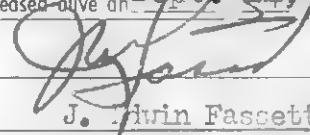
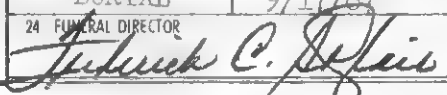

CERTIFICATE OF DEATH

12365

1 PLACE OF DEATH a. COUNTY <u>DELAWARE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>JOHNS HOPKINS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOHNS HOPKINS</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CAMPBELL MARYLAND HOSPITAL, INC.</u>		d. STREET ADDRESS <u>R.F.D. #2 AIRSV</u>	
3 NAME OF DECEASED (Type or print) <u>FIRST MIDDLE LAST</u> <u>BARRY STANLEY HEINT</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>NEG. OLD</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MARCH 13, 1895</u>
9 AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>JOHNS HOPKINS, MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVI STANLEY, SR.</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE STANLEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>220-10-2136A</u>	
17. INFORMANT <u>LEVI HEINT</u>		Address <u>RFD #2 JOHNS HOPKINS, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 19, 1967</u> to <u>Sept. 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept. 9, 1967</u> , and that death occurred at <u>9</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Edwin Facchetti, M.D.</u>		22b. DATE SIGNED <u>Sept. 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Facchetti, M.D.</u>		22d. ADDRESS <u>500 Pine Street Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ALLEGES</u>	23d. LOCATION (City or Town) (County) (State) <u>ALLEGES DO. MD.</u>
24. FUNERAL DIRECTOR <u>Frederick C. DeLieu</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
ADDRESS <u>CAMPBELL, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12357						CERTIFICATE OF DEATH			12366		
1 PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CALBIE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Calbrie</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CANTINE HARTLAND HOSPITAL, INC.</u>						d. STREET ADDRESS <u>RD #2 ALBING, MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>MOLOCK MOLOCK HOPKINS</u>						4. DATE OF DEATH Month Day Year <u>SEPTEMBER 14 1967</u>					
5 SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 30, 1890</u>		9. AGE (In years last birthday) yrs <u>77</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11 BIRTHPLACE (County & State, or foreign country) <u>DORCHESTER CO., MD.</u>				12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CALEB MOLOCK</u>						14. MOTHER'S MAIDEN NAME <u>ELIZA STANLEY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>200-00-7791</u>		17. INFORMANT <u>VI LENA BROWN</u> Address <u>RD #2 CALBIE, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>4201</u> DUE TO <u>Coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>3wks</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 19, 1967</u> , to <u>Sept. 14, 1967</u> ; that (I) (we) last saw the deceased alive on <u>Sept. 14, 1967</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.											
22a. SIGNATURE 						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 15, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>						22d. ADDRESS <u>623 High Street Cambridge, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>9/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>AIREYS</u>				23d. LOCATION (City or Town) (County) (State) <u>AIREYS MD.</u>	
24. FUNERAL DIRECTOR 						ADDRESS <u>CALBIE, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE 	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12358

CERTIFICATE OF DEATH

12367

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN 1b 16 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS ROUTE #2 Box 183		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES HENRY JONES				4. DATE OF DEATH Month SEPTEMBER Day 9 Year 1967			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09-18-83	
9. AGE (in years, day, birthday, yrs) 83		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA	
13. FATHER'S NAME HILLIARD JONES				14. MOTHER'S MAIDEN NAME FRANCES LEE JONES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 221-05-0159		17. INFORMANT Address RECORDS OF THE EASTERN SHORE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO (b) UREMIA DUE TO (c) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 4 MIN. 2 DAYS 1 WK.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT 8, 1967 to SEPT 9, 1967 that (I) (we) last saw the deceased alive on SEPT 9, 1967 , and that death occurred at 11:30 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Sean M. Killoran</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 9, 1967	
22c. PHYSICIAN'S NAME (Type) SEAN KILLORAN M.D.				22d. ADDRESS EASTERN SHORE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Sept. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Thompsontown Cemetery		23d. LOCATION (City or Town) (County) (State) Near East New Market, Md.	
24. FUNERAL DIRECTOR <i>Trampton Funeral Home Federal City, Md</i>				25a. REC'D BY REGISTRAR DATE SEP 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12359

12368

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND X			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Dorchester</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c LENGTH OF STAY IN 1b <u>9 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>			d. STREET ADDRESS <u>Main Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wilbur</u> Last <u>Kready</u>			4 DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1967</u>		
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-22-12</u>	9 AGE (In years last b rthday) <u>54</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11 BIRTHPLACE (County & State, or foreign country) <u>PA. U.S.A.</u>	
13. FATHER'S NAME <u>Elias E. Kready</u>			14. MOTHER'S MAIDEN NAME <u>Ensminger (ANNIE)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes UNKNOWN</u>		16. SOCIAL SECURITY NO <u>199-03-0331</u>		17. INFORMANT Address <u>Eastern Shore State Hospital (Med. Records)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <u>Chronic endocarditis. Aortic insufficiency</u> lost } DUE TO (c) <u>3 years</u>					INTERVAL BETWEEN DEATH AND DEATH SET <u>3 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-19</u> , 19 <u>67</u> , to <u>9-27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>September 27 1967</u> and that death occurred at <u>7:35</u> AM, from causes and on the date stated above.					
22a SIGNATURE <u>Carlos F. Barroso</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF. PHYS. <input type="checkbox"/>		22b DATE SIGNED <u>9-27-67</u>	
22c PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>		22d ADDRESS <u>Hurlock Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Sept 30 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>East New Market, Maryland</u>		
24 FUNERAL DIRECTOR <u>LeCompte Funeral Service, Cambridge, Maryland</u>			25a REC'D BY REGISTRAR DATE <u>SEP 23 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

VR A15 (4)
25M 1/67

A-3V
10/19/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12250

CERTIFICATE OF DEATH

12360

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg d. STREET ADDRESS R.F.D. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Alonso Last Lake		4. DATE OF DEATH Month September Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898 April 24, 1898
9. AGE (In years last birthday) XX 69		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 07 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (County & State, or foreign country) Dorchester County
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Steve Lake	
14. MOTHER'S MAIDEN NAME Mary (Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 215-38-0385		17. INFORMANT Mrs. Anne Hughes, Williamsburg, Md. R.F.D.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Coronary insufficiency DUE TO (c) 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypochromic anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 23, 1967 to September 25, 1967 , that (I) (we) last saw the deceased alive on September 24, 1967 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Carlos F Barroso		22b. DATE SIGNED 9-28-67	
22c. PHYSICIAN'S NAME (Type) CARLOS F BARROSO		22d. ADDRESS Hurlock Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep't. 30, 1967	
23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION (City, town or county) (State) Near Hurlock, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalburg, Md.		25a. REC'D BY REGISTRAR Oct 5 1967	
25b. REGISTRAR'S SIGNATURE J. J. Frampton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CAMBRIDGE		c. LENGTH OF STAY IN 1b 11 mos. 14 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS 724 MADISON STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) OLIVER BURKE LEWIS		4 DATE OF DEATH SEPT. 15 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-91
9 AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WICOMICO, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME RILEY CARROLL LEWIS		14. MOTHER'S MAIDEN NAME FLORENCE DENNIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16 SOCIAL SECURITY NO 214-12-0588A	
17 INFORMANT MED. RECORDS Address EASTERN SHORE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO (b) Senile cachexia DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 24, 1966 , to September 15, 1967 , that (I) (we) last saw the deceased alive on September 15, 1967 , and that death occurred at 12:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Carlos F. Barroso M.D.		22b. DATE SIGNED 9-15-67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO		22d. ADDRESS Hurlock, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/16/67	23c. NAME OF CEMETERY OR CREMATORY Washington	23d. LOCATION (City or Town) (County) (State) Hurlock, Md.
24. FUNERAL DIRECTOR John S. Murphy, East Mt. Market		25a. REC'D BY REGISTRAR SEP 18 1967	25b. REGISTRAR'S SIGNATURE John S. Murphy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12362

12371

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cambridge-Maryland Hospital</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Julia Alberta Marshall</i>		4. DATE OF DEATH Month <i>9</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/16/1891</i>
9. AGE (In years last birthday) yrs <i>76</i>		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Owner & operator Nursing Home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John H. Lyons</i>		14. MOTHER'S MAIDEN NAME <i>Ada Lowery</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO <i>219-07-0896</i>	
17. INFORMANT <i>Sewell Lyons, Trappe, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myelocytic Leukemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 month 5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/3/67</i> , 19 to <i>9/28/67</i> , 19, that (I) (we) last saw the deceased alive on <i>9/28/67</i> , 19, and that death occurred at <i>10:30</i> A.M., from causes on and on the date stated above.			
22a. SIGNATURE <i>Lawrence Maryanov</i> M.D.		22b. DATE SIGNED <i>10/1/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Lawrence Maryanov MD</i>		22d. ADDRESS <i>610 Race St Cambridge, Md 21613</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/1/1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Upper Bambury</i>		23d. LOCATION (City or Town) (County) (State) <i>Trappe, Md.</i>	
24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM & SON, Easton, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 3 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper's, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12263									
12372									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 604 Race Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First GEORGE Middle O. Last MEIZER					4. DATE OF DEATH Month Sept. Day 8 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1873		9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR: Months 93 Days 93 Hours 93 Min. 93	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker-Retired			10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair			11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk					14. MOTHER'S MAIDEN NAME Unk				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. James Aaron, Cambridge, Maryland Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 5 yrs DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/2/67 19 to 9/8/67 19, that (I) (we) last saw the deceased alive on 9/8/67 19, and that death occurred at 6 AM , from the causes and on the date stated above.									
22a. SIGNATURE Lawrence Maryanov					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 9/9/67	
22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov					22d. ADDRESS 604 Race St Cambridge, Md 21613				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 10, 1967		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery			23d. LOCATION (City, town or county) (State) East New Market, Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland ADDRESS					25a. REC'D BY REGISTRAR SEP 11 1967 DATE		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

CERTIFICATE OF DEATH

12373

12364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST DENTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS R.F.D. #3	
3. NAME OF DECEASED (Type or print) CLEMENT HENRY MELUNEY		4. DATE OF DEATH Month SEPTEMBER Day 10 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-30-85
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONT. BUILDER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME TILGHMAN MELUNEY		14. MOTHER'S MAIDEN NAME MARY NOBLE MELUNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PYELO NEPHRITIS DUE TO (c) SEPTICEMIA			
INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 WK 12 HRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. Month, Day, Year 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from SEPT 9 , 19 67 , to SEPT 10 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from causes and on the date stated above.			
22a. SIGNATURE Sean M Killoran		22b. DATE SIGNED SEP 10, 1967	
22c. PHYSICIAN'S NAME (Type) SEAN KILLORAN M.D.		22d. ADDRESS EASTERN SHORE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-13-67	23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery	23d. LOCATION (City or Town) (County) (State) Federalburg, Caroline Md.
24. FUNERAL DIRECTOR Harvey Williamson Federalburg		25a. REC'D BY REGISTRAR DATE SEP 10 1967	
25b. REGISTRAR'S SIGNATURE James J. ...			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12265

12374

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

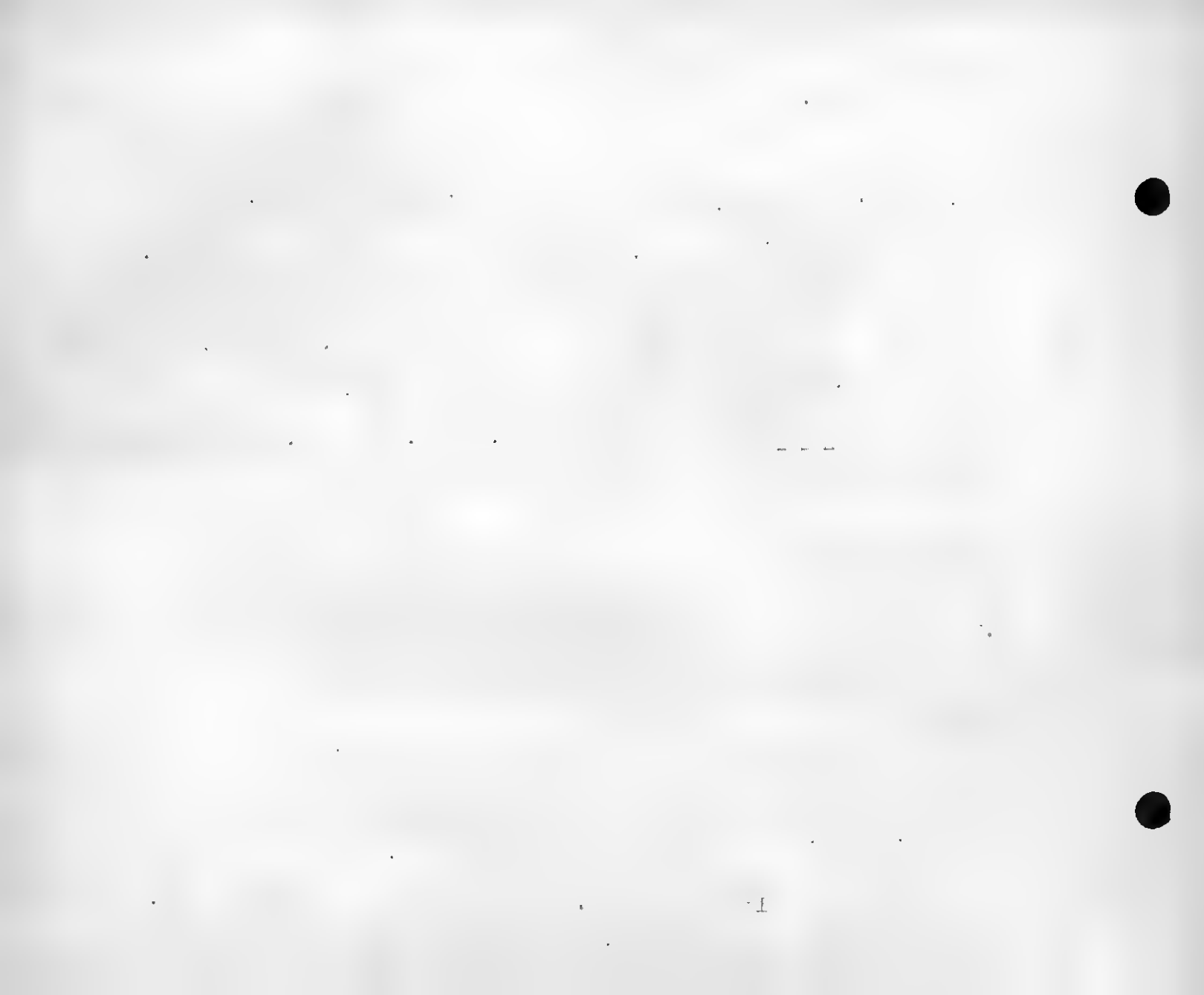
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived if institut on: Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>Wicomico</u> <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c LENGTH OF STAY IN 1b <u>Bye Home 9 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d STREET ADDRESS <u>Salisbury</u>	
3 NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>		4 DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/18/1870</u>
9 AGE (in years last birthday) yrs <u>97</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND - U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>C. James Wilkey</u>		14. MOTHER'S MAIDEN NAME <u>Stewart</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16 SOCIAL SECURITY NO <u>UNKNOWN</u>	
17 INFORMANT <u>Eastern Shore State Hospital (Med. Records)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVA. BETWEEN ONSET AND DEATH			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED Whole of work <input type="checkbox"/> Not Whole of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory street office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that <u>1</u> (this hospital) attended the deceased from <u>9-16</u> , 19 <u>63</u> , to <u>9-5</u> , 19 <u>67</u> that <u>1</u> (we) last saw the deceased alive on <u>9-5</u> 19 <u>67</u> , and that death occurred at <u>1:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>R. J. Perdue</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Sept 7 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Cambridge, Maryland</u>
24 FUNERAL DIRECTOR <u>LECOMPT FURNERAL SERVICE, CAMBRIDGE, MD.</u>		25a REC'D BY REGISTRAR <u>SEP 7 1967</u>	
ADDRESS		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10/13/57		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						d. STREET ADDRESS RFD #2, Bucktown Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REX W. NEAL, Sr		4. DATE OF DEATH Sept. 13 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 8, 1890/		9. AGE (In years last birthday) 76 7/7 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Neal		14. MOTHER'S MAIDEN NAME Mary Elizabeth Stoker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. Rex W. Neal, Sr., RFD 2, Cambridge, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE GI HEMORRHAGE 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF COLON DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH MINUTES 6-10 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (1) (this hospital) attended the deceased from 9-9 , 19 67 , to 9-13 , 19 67 , that (1) (we) last saw the deceased alive on 9-13 , 19 67 , and that death occurred at 9:38 M. from the causes and on the date stated above.									
22a. SIGNATURE James F. McCartar		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-18-67		22c. PHYSICIAN'S NAME (Type) JAMES F. MCCARTAR		22d. ADDRESS Box 386 Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland		24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland	
25a. REC'D BY REGISTRAR SEP 25 1967		25b. REGISTRAR'S SIGNATURE [Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12367

CERTIFICATE OF DEATH

12376

1 PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN 1b WOOLFORD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS None	
3 NAME OF DECEASED (Type or print) CAROLYN C.		4 DATE OF DEATH SEPTEMBER 10 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1873
9. AGE (in years last birthday) 94 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) York, Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY CLAU		14. MOTHER'S MAIDEN NAME Ernestine Gambrill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO unk	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CONGESTIVE HEART FAILURE DUE TO (c) 1 WK	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT 9 , 1967, to SEPT 10 , 1967, that (I) (we) lost the deceased alive on SEPT 10 , 1967, and that death occurred at 8:25 PM , from causes and on the date stated above			
22a. SIGNATURE Sam M. Killoran		22b. DATE SIGNED SEP 10 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/13/1967	
23c. NAME OF CEMETERY OR CREMATORY Epithany Cemetery		23d. LOCATION (City or Town) (County) (State) Odenton, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Md		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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- 1 -
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12368

CERTIFICATE OF DEATH

12377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rachel-Lansdale</u>		c. LENGTH OF STAY IN 1b <u>20 1 13</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENSBORO</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Lowe</u> Last <u>Ober</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-09-77</u>	9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Green</u>				14. MOTHER'S MAIDEN NAME <u>Clunie Lowe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>219-24-1664</u>		17. INFORMANT <u>Med. Records</u> Address <u>Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>Sinistery</u>						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>pm</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-17</u> , 19 <u>66</u> , to <u>9-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-14</u> 19 <u>67</u> , and that death occurred at <u>8:00</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Rene E. Smith</u>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rene E. Smith</u>				22d. ADDRESS <u>Eastern Shore State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		23d. LOCATION (City or Town) (County) (State) <u>Greensboro, Md.</u>	
24. FUNERAL DIRECTOR <u>J. E. Boulaire</u>				ADDRESS <u>Greensboro, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>12369</div> <div>12378</div> <div>12369</div> <div>12378</div>											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN ID 74 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						d. STREET ADDRESS RFD #3, Ross Neck Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARSHALL Middle / Last PARKER			4. DATE OF DEATH Month Sept. Day 7 Year 1967			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan 10, 1899			9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		
10b. KIND OF BUSINESS OR INDUSTRY Dirt			11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penna.			12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Benjamin Parker		
14. MOTHER'S MAIDEN NAME Margaret Killion			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No Yes			16. SOCIAL SECURITY NO. (If none, give war or dates of service) 127-03-7089			17. INFORMANT Mrs. Margaret P. Parker, Cambridge, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 25th 1967 , that (I) (we) last saw the deceased alive on 9/7 1967 , and that death occurred on 9/7 1967 , from the causes and on the date stated above.											
22a. SIGNATURE W. E. GUNBY M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) W. E. GUNBY 22d. ADDRESS Cambridge, Md.											
22b. DATE SIGNED 9/7 1967											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF Sept 9, 1967			23c. NAME OF CEMETERY OR CREMATORY Lee F. H. Crematory			23d. LOCATION (city, town or county) (State) Washington, D. C.		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR DATE SEP 11 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12379

12370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wic</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>		c. LENGTH OF STAY IN 1b <u>54 1/2 mos. 19 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>Camden Ave. Extd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ula</u> Middle <u>ORVILLE</u> Last <u>PENNEWELL</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-09</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Products</u>	9. AGE (In years last birthday) <u>57</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levin Pennewell</u>		14. MOTHER'S MAIDEN NAME <u>Lydian M. Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-07-3614</u>	
17. INFORMANT <u>Mr. R. Long</u>		Address <u>Mrs. Iris H. Pennewell (Wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Labor Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		Camden Ave. Extd., Fruitland, Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>N/A</u>	
20c. TIME OF INJURY Month Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE <u>E. Fernandez</u>		22b. DATE SIGNED <u>9/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EFRAIN C. FERNANDEZ, MD</u>		22d. ADDRESS <u>Eastern Shore State Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN 1b 6 MONTHS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOOPERSVILLE		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) GARFIELD PHILLIPS		4. DATE OF DEATH Month SEPTEMBER Day 16 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-28-81
9. AGE (In years last birthday) 85 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL PHILLIPS		14. MOTHER'S MAIDEN NAME UNKNOWN Jane Aaron	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN NO		16. SOCIAL SECURITY NO 219-10-5111A	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. PNEUMONIA DUE TO PROB. MYOCARDIAL INFARCT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 DAYS (c) 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SYNDROME, SENILE BRAIN DISEASE		19. WAS ALTHOUGH PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 3-22-1967 to 9-16-1967 that (1) (the) last saw the deceased alive on 9-16-1967 and that death occurred at 8:45 AM , from causes and on the date stated above			
22a. SIGNATURE Edward Lewis Jr.		22b. DATE SIGNED 9-16-67	
22c. PHYSICIAN'S NAME (Type) EDWARD LEWIS JR., M.D.		22d. ADDRESS ESSH, CAMBRIDGE, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 19, 1967	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d. LOCATION (City or Town) (County) (State) Cambridge Md.
24. FUNERAL DIRECTOR Rebecca R. Moore		25a. REC'D BY REGISTRAR SEP 22 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE (rural)</u>		c. LENGTH OF STAY IN 1b <u>Unknown</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>Unknown</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JANE</u> First <u>Powell</u> Middle <u>Powell</u> Last		4. DATE OF DEATH <u>Sept 16</u> 19 <u>67</u> Month <u>16</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-1874</u> 9. AGE (In years last birthday) <u>93</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William M. Wise</u>		14. MOTHER'S MAIDEN NAME <u>Ella Vandevanter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMATION <u>Hospital Records</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis and Chronic Brain Syndrome</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>ED</u> (this hospital) attended the deceased from <u>12-4-</u> , 19 <u>65</u> , to <u>9-16-</u> , 19 <u>67</u> that (1) <u>yes</u> (no) lost saw the deceased alive on <u>9-16-</u> 19 <u>67</u> , and that death occurred at <u>6:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>E. Lewis</u>		22b. DATE SIGNED <u>9-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR. MD</u>		22d. ADDRESS <u>ESSH CAMBRIDGE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 19, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Leeburg, Va.</u>
24. FUNERAL DIRECTOR <u>Le Compte Funeral Service, Cambridge, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

12373		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12382	
CERTIFICATE OF DEATH					
1 PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY CECIL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN IB 12 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last JAHUE FRANKLIN RAKES			4. DATE OF DEATH Month Day Year SEPTEMBER 11 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/79	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
13. FATHER'S NAME WILLIAM C. RAKES			14. MOTHER'S MAIDEN NAME VICTORIA ALICE HURD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 218-18-5384		17. INFORMANT HOSPITAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 days 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis, Benign Prostate hyperplasia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/16, 1955, to 9/11, 1967, that (I) (we) last saw the deceased alive on 9/11 19 67, and that death occurred at 2:10 P.M. from causes and on the date stated above.					
22a. SIGNATURE Carlos F. Barros			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/11/67
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO			22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-14-1967	23c. NAME OF CEMETERY OR CREMATORY Conowingo Cem.		23d. LOCATION (City or town) (County) (State) Conowingo Cecil Md.	
24. FUNERAL DIRECTOR Richard L. Gooch			25a. REC'D BY REGISTRAR SEP 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12374					12383						
1. PLACE OF DEATH a. COUNTY <u>Lorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>Few Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nannie Kelly Richardson</u>			First Middle Last		4. DATE OF DEATH <u>9 30 1967</u>		Month Day Year				
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/16/1891</u>		9. AGE (In years last birthday) <u>76</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework, Own Home</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Kelly</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Thompson</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Crawford Richardson, Cambridge Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>10 yrs</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9/15/67</u> 19 <u>67</u> to <u>9/20/67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/20/67</u> and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Lawrence Maynard</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/22/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Lawrence Maynard</u>					22d. ADDRESS <u>610 Racco Cambridge Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge Md</u>				
24. FUNERAL DIRECTOR <u>Edw. H. Kuthroughly, East New Market, Md</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julian J. J...</u>				

12375

CERTIFICATE OF DEATH

12384

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	
c. LENGTH OF STAY IN 1b 1 1/2 YRS.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS 148 OCEAN CITY ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN THOMAS SAVAGE		4. DATE OF DEATH Month Day Year SEPT. 18 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/77
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - Retired Lumberman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) - Georgetown, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN T. SAVAGE		14. MOTHER'S MAIDEN NAME ANNIE BROWN Gordy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - No		16. SOCIAL SECURITY NO - 180-03-6609	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia (c) Chronic Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 66 , to 9/18 , 19 67 , that (I) (we) last saw the deceased alive on 9/18 , 19 67 , and that death occurred at 3:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Carlos F. Barros M.D.		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROS		22d. ADDRESS E.S. S. HOSPITAL, CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 21 1967	
		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN ID 50 years		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Railroad Avenue				e. STREET ADDRESS Railroad Avenue				6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD		Middle SHERMAN		Last SR.		4. DATE OF DEATH Month September 12		Year 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 29, 187		9. AGE (In years last birthday) 9 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee of Continental Can Co.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Sherman				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-03-2007		17. INFORMANT Address Mrs. Rosetta Sherman, Hurlock, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8</u> , 1967, to <u>9-15</u> , 1967, that (I) (we) last saw the deceased alive on <u>9-15</u> , 1967, and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard G. Bilodeau</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-22-67	
22c. PHYSICIAN'S NAME (Type) RICHARD G. BILODEAU				22d. ADDRESS CITY OFFICE BLDG., CAMBRIDGE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION (City, town or county) Near Hurlock, Maryland			
24. FUNERAL DIRECTOR <u>James Hampton Jr.</u>				ADDRESS J. J. Hampton and Son, Hockessin, Maryland		25a. REC'D BY REGISTRAR DATE SEP 26 1967			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12386									
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital					d. STREET ADDRESS 403 Bayly Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARIE ELZEY SLACUM			First Middle Last		4. DATE OF DEATH Month Day Year Sept. 7, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1920		9. AGE (In years last birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Elzey					14. MOTHER'S MAIDEN NAME Rosie Grey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Mr. Wyatt Slacum, Cambridge, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast carcinoma 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-5 , 19 67 , to 9-7 , 19 67 , that (I) (we) last saw the deceased alive on 9-7-67 , 19 67 , and that death occurred at 11:55 PM , from the causes and on the date stated above.									
22a. SIGNATURE Richard G. Bilodeau					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-8-67		
22c. PHYSICIAN'S NAME (Type) RICHARD G. BILODEAU					22d. ADDRESS CAMBRIDGE, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR SEP 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12378

12387

1 PLACE OF DEATH a COUNTY <u>DORCHESTER</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c LENGTH OF STAY IN TB <u>LIFE</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		09.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CAMBRIDGE MARYLAND HOSPITAL, INC.</u>		d STREET ADDRESS <u>800 PARK LANE</u>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE JACKSON STERLING SPICER</u>		4 DATE OF DEATH Month Day Year <u>SEPT. 9, 1967</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGROID</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9, 1925</u>
9 AGE (In years last birthday) <u>42</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>DORCHESTER CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM JACKSON</u>		14 MOTHER'S MAIDEN NAME <u>ANNIE EWEELS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>220-10-6147</u>	
17 INFORMANT <u>WILLIAM JACKSON</u>		Address <u>CAMBRIDGE, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO (b) <u>Pancreatitis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 30, 1967</u> to <u>Sept. 9, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept. 9, 1967</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a SIGNATURE <u>J. Edwin Fennell, M.D.</u>		22b DATE SIGNED <u>Sept. 10, 1967</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS <u>503 High St. Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETHUEL</u>		23d. LOCATION (City or Town) (County) (State) <u>CAMBRIDGE DC., MD.</u>	
24. FUNERAL DIRECTOR <u>Edwin C. Rogers</u>		ADDRESS <u>CAMBRIDGE, MD.</u>	
25a. RECD BY REGISTRAR <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12279

12388

1 PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) P. STATE MD. QUEEN ANNE'S b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN 1b 8 MONTHS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHURCH HILL			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) HURVEY		First Middle Last STARKEY		4. DATE OF DEATH SEPT. 14 1967		Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/80	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE THOMAS STARKEY				14. MOTHER'S MAIDEN NAME MARTHA WALLS STARKEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 218-20-9016A		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute aleukemic leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/24 1967 to 9/14 1967 , that (I) (we) last saw the deceased alive on 9/14 1967 , and that death occurred at 8 AM , from causes and on the date stated above.							
22a. SIGNATURE Carlos F. Barros				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/14/67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARRUSO				22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 17		23c. NAME OF CEMETERY OR CREMATORY CHURCH HILL		23d. LOCATION (City or town) (County) (State) CHURCH HILL MD.	
24. FUNERAL DIRECTOR Edgar L. Lane Church Hill Md.				25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMPBELL</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMPBELL</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CAMPBELL MARYLAND HOSPITAL, INC.</u>						d. STREET ADDRESS <u>512 CEDAR STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>GERMANUS</u> <u>TILGEMAN</u>						4. DATE OF DEATH Month Day Year <u>SEPTEMBER</u> <u>16</u> , <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGROID</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 6, 1926</u>		9. AGE (in years last birthday) <u>41</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DORCHESTER CO., MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>B. ENJAMIN TILGEMAN</u>						14. MOTHER'S MAIDEN NAME <u>ROSIE KELL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>-----</u>		17. INFORMANT <u>A. J. CLICH</u>				Address <u>CAMPBELL, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO (b) <u>1 day</u> DUE TO (c) <u>1 day</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Gastroenteritis (3 weeks)</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 27, 1967</u> to <u>Sept. 16, 1967</u> that (I) (we) lost saw the deceased alive on <u>Sept. 16, 1967</u> , and that death occurred at <u>-----</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 18, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. J. Fennell, M.D.</u>						22d. ADDRESS <u>613 N. High St. Campb., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MADISON</u>		23d. LOCATION (City or Town) (County) (State) <u>MARYLAND</u>					
24. FUNERAL DIRECTOR <u>[Signature]</u>						ADDRESS <u>CAMPBELL, MD.</u>		25a. REC'D BY REG. STRAR DATE <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12281									
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 2 weeks					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital					d. STREET ADDRESS School & Somerset Streets				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LETA FLORENCE VINCENT			First Middle Last		4. DATE OF DEATH September 1, 1967		Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1893		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Bonneville					14. MOTHER'S MAIDEN NAME Florence Collins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-44-2622		17. INFORMANT Mrs Thomas A. Smith, Pocomoke, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary & peripheral embolus DUE TO (b) Pancreatitis DUE TO (c) Acute viral hepatitis & pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 7 days 14 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 2:30 PM from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) [Signature]					22d. ADDRESS Cambridge, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-4-1967		23c. NAME OF CEMETERY OR CREMATORY First Baptist		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland		
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR SEP 28 1967		25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #1d Film #G393 10/2/57 ph

12382

CERTIFICATE OF DEATH

12391

1 PLACE OF DEATH a COUNTY <u>DORCHESTER</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HURLOCK</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BERLIN</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Commerce & Mulberry</u>		d STREET ADDRESS <u>P.D. ST. MARTINS</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET EMMA WEST</u>		4. DATE OF DEATH Month Day Year <u>SEPT 25 1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 28 1875</u>
9. AGE (In years last birthday) <u>92</u> yrs		10. IF UNDER 25 IF UNDER 24 HRS Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WHITON MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>WILLIAM J. DAVIS</u>		14 MOTHER'S MAIDEN NAME <u>NANCY WEBB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>160</u>	
17 INFORMANT Address <u>Mrs EDNA WITGATLEY HURLOCK MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar</u> 470X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Senile cachexia</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 3, 1966</u> , to <u>September 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>September 25, 1967</u> , and that death occurred at <u>2:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Carlos F. Barroso</u> M.D.		22b. DATE SIGNED <u>September 25 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>		22d. ADDRESS <u>Hurlock Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>	23d. LOCATION (City or Town) (County) (State) <u>POWELLVILLE WIC. MD.</u>
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE
		DATE <u>SEP 28 1967</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12383

12383

<p>1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dorchester</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Hurlock</u></p>				<p>c. LENGTH OF STAY IN 1b <u>3 weeks</u></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>				<p>d. STREET ADDRESS <u>Adelock</u></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>Isadore</u> Middle <u>Whitaker</u> Last <u>Whitaker</u></p>				<p>4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1967</u></p>			
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>C</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>4/29/25</u></p>	
<p>9. AGE (In years last birthday) <u>42</u> yrs.</p>		<p>10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u></p>		<p>11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u> </u></p>			
<p>11. BIRTHPLACE (State or foreign country) <u>GA</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>Unknown</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Unknown</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>				<p>16. SOCIAL SECURITY NO. <u>354-84-5398</u></p>		<p>17. INFORMANT <u>State Police</u> Address <u> </u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head.</u></p>							<p>INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u></p>
<p>761A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in head with 22 calibre rifle.</u></p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:30P</u> p.m. <u>9/17</u> 1967</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u> </u> at work <u> </u></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u></p>		<p>20f. (City or town) (County) (State) <u>RFD-Hurlock, Dor.- Md.</u></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input checked="" type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.</p>				<p>22. DATE SIGNED <u>9/19/67</u></p>			
<p>EXAMINER'S NAME (Type) <u>Alfred R. Maryanov, M.D.</u></p>				<p>610 Race St., Cambridge, Md. 21613 Address (Street, city, town, or county)</p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u></p>		<p>23b. DATE THEREOF <u>9/20/67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Salem</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Salem Md.</u></p>	
<p>24. FUNERAL DIRECTOR <u>Wells West</u></p>				<p>25a. REC'D BY REGISTRAR DATE <u>SEP 21 1967</u></p>			
<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>				<p> </p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12394											
12393											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge						c. LENGTH OF STAY IN 1b Lifetime					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Md. Hospital						d. STREET ADDRESS 905 Talisman Lane					
3. NAME OF DECEASED (Type or print) First Wrightson Middle Willey Last Willey						4. DATE OF DEATH Month Sept. Day 8 Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1901		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months 6 Days 6 Hours 6 Min. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Manager				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (County & State, or foreign country) Lakesville, Dorchester				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Willey						14. MOTHER'S MAIDEN NAME Isabella Dixon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-07-7701		17. INFORMANT Address Mrs. Willey 905 Talisman Lane					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 1 hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 to 9-8 , 19 67 , that (I) (we) last saw the deceased alive on 9-7 , 19 67 , and that death occurred at 7:45 AM, from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) [Name]						22b. DATE SIGNED [Date]					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 10 '67		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		23d. LOCATION (City, town or county) (State) Cambridge Md.			
24. FUNERAL DIRECTOR [Signature]						ADDRESS Cambridge Md.		25a. REC'D BY REGISTRAR SEP 13 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12385									
12394									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Dorchester MARYLAND					a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
c. LENGTH OF STAY IN 1b 6 hr. 5 minutes					d. STREET ADDRESS Aurora Street				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital, Inc.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
						Wilson		September 16 19 67	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/16/67		6 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
					Dorchester Maryland		U.S.A.		
13. FATHER'S NAME Preston Thomas Anderson					14. MOTHER'S MAIDEN NAME Mae Thomas Wilson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mae Thomas Wilson 527 Washington Street				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe prematurity - wt 1¹/₂ lbs. 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from September 16 19 67 , to September 16 19 67 , that (I) (we) last saw the deceased alive on September 16 19 67 , and that death occurred at 5P M, from the causes and on the date stated above.									
22a. SIGNATURE Dr. J. Edwin Fassett					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-18-67		
22c. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett					22d. ADDRESS 623 High Street, Cambridge, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 9-18-67		23c. NAME OF CEMETERY OR CREMATORY Cambridge-Maryland Hospital		23d. LOCATION (City, town or county) (State) Cambridge, Maryland		
24. FUNERAL DIRECTOR Virginia Skinner-Coughlin					ADDRESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge		
					DATE SEP 20 1967				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12386		12395	
1. PLACE OF DEATH a. COUNTY <u>Caroline</u> <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>20.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Marys Nursing Home</u>		d. STREET ADDRESS <u>120 Hammond Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Woolford</u> Last <u>Woolford</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>10</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1900</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>66</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>LEWIS WOODFORD</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE NICHOLS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DORA PERTINS - CHESTER, PA.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Haert Failure Phase</u> <u>ACUTE</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic HeartDisease</u> 4 yrs (c) <u>Generalized Arteriosclerosis</u> 10yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Rheumatid Arhrhitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/21/66</u> , 19 <u>66</u> , to <u>9/10/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/9/67</u> , 19 <u>67</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Harold B. Plummer</u>		22b. DATE SIGNED <u>9-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harold B. Plummer</u>		22d. ADDRESS <u>Maple Ave., Preston, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RICHARDS</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton Talbot MD</u>
24. FUNERAL DIRECTOR <u>Barbara L. Dashiell, 426 Dover St.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

